ENSURING THE SUCCESS OF THE NEW MEDICARE DRUG BENEFIT

The Medicare Modernization Act (MMA) made many changes to the Medicare Program including adding a voluntary prescription drug benefit that will be available on January 1, 2006. CMS is implementing the drug benefit in a way that permits and encourages a range of options for Medicare beneficiaries to augment the standard Medicare coverage with drug coverage. These options include coverage through employer plans, Medicare Advantage – Prescription Drug (MA-PD) plans and/or prescription drug plans (PDPs), and through charitable organizations and State pharmaceutical assistance programs. The law also permits Medicare to adopt proven practices that have led to reliable, affordable health plan options in other settings serving diverse populations of Americans, such as the Federal Employees Health Benefits (FEHB) Program.

An FEHB-Style Partnership at Medicare

In implementing the Medicare prescription drug benefit, CMS is taking unprecedented steps to obtain extensive public input to assure the benefit's success, as well as adopting practices that have proven effective in FEHB and other large systems for providing up-to-date health coverage. CMS is working harder than ever with beneficiary advocates, potential drug plan sponsors, retiree groups, unions, employers, and the States to obtain input and develop partnerships that ensure the success of the Medicare drug benefit.

In a little more than a year, we have published proposed and final regulations implementing the major elements of the new Medicare drug benefit program and the new Medicare Advantage program. We received thousands of helpful public comments that we have been able to incorporate and address in our final regulations. CMS is committed to a continuing open dialogue with our PDP partners, much like the US Office of Personnel Management maintains its ongoing relationship with the health plans that participate in the FEHB Program. In keeping with our implementation strategy, we have already invited them to review and comment on our application and bidding materials. Further CMS guidance on these materials will be issued in conjunction with the final rules. In addition, we continue our commitment to open communication with plans by building on the more than 20 MMA-related open door forum events held in the last 6 months.

CMS will launch an extensive training program for potential plan sponsors focused on program requirements and application procedures that will begin in Baltimore later this month. We will hold this training again in San Diego and New Orleans during the first week of February to give more potential sponsors an opportunity to learn about the program. Materials describing the Indian Health Care Provider network has been developed by the Indian Health Service and will be included in the packet of briefing materials for potential plan sponsors. We will create an ongoing forum for information exchange through weekly follow-up phone calls with applicants. CMS will focus one of these weekly calls on the Indian Health Care Provider network. The purpose is to familiarize potential plan sponsors with the unique design of the Indian Health Care Provider network serving American Indians and Alaska Natives. Later in the year, we will

provide targeted assistance to applicants on the bidding process, our claims submission requirements, and issues related to enrollment and payment systems. To facilitate and expedite the application and bidding process, like our FEHB counterparts, we also will engage in discussions with individual plan sponsors as needed to address concerns and resolve issues.

Financial Structure and Incentives

Bidding for the Prescription Drug Benefit

Beneficiary premiums for the new drug benefit will be determined by the results of a plan competitive bidding process. The premiums for basic coverage are expected to average less than $37 dollars per month in 2006. The specific premium for each plan will be determined by its bid.

By law, and as reflected in the final rule, all prescription drug plans and Medicare Advantage plans will submit a bid for the cost of providing the drug benefit in the service area to a typical beneficiary. The typical beneficiary will be a statistical average of age and health status of all Medicare beneficiaries nationally. CMS will review the bids, and the cost of the basic benefit portion of all the approved bids will be compiled into a national weighted average, which serves as a benchmark for purposes of setting premiums. The weights will be the plans' enrollment shares in the prior year. For the first year of the program, CMS has developed a system to allocate weights.

Generally, the beneficiary premium for each plan's basic drug benefit will be 25.5 percent of the average total plan costs, plus or minus any difference between the national average of all bids (the benchmark) and the plan's bid. Other factors will affect the premium that each beneficiary pays:

- If the beneficiary qualifies for low-income assistance, the premium will be reduced on a sliding scale, or eliminated entirely, depending on the beneficiary's income and assets, and the difference will be paid by Medicare.
- If a beneficiary receives drug coverage through an MA-PD plan, the basic drug premium may be reduced or eliminated by applying plan rebates that result from bids below the benchmark for the A/B benefit.
- If the beneficiary does not enroll in the new drug benefit during the open enrollment period that ends in May 2006, and does not maintain creditable coverage, then the beneficiary will have to pay higher costs later.
- If the beneficiary chooses a plan that features supplemental coverage over and above the basic drug benefit, a supplemental premium may apply. In the case of drug plans, enrollees pay the full cost of supplemental coverage. In the case of MA-PD plans, the supplemental premium may be reduced or eliminated as a result of the application of plan rebates that result from bids below the benchmark for the A/B benefit.

The competitive bidding structure permits each plan to cover its costs – Medicare is not setting a price for drug coverage – but strongly encourages plans to bid at the lowest cost. This is because plans that have higher bids will also have higher beneficiary premiums, making them less attractive to beneficiaries.

Government Subsidies and Risk-Sharing

The structure of Medicare Part D is designed to encourage risk-bearing entities to offer drug benefits. The government will be taking on a significant amount of both the total cost and the total risk of the benefit:

- First of all, the benefit is heavily subsidized, with the government paying 74.5 percent of the average plan costs for basic coverage.
- Second, while the plan bids will be based on a statistical average of age and health status of all Medicare beneficiaries nationally, payments to the plans will be fully risk-adjusted for the beneficiaries who actually join the plan. The risk adjustment amounts are being determined through another public comment process, and will account for factors including demographics, diseases, income, and institutional status that may be associated with variations in the drug costs for plans.
- Third, once the beneficiary has paid $3,600 out of pocket, government reinsurance begins paying 80 percent of drug spending with the plan paying only 15 percent and the beneficiary paying the other 5 percent.
- Fourth, the cost sharing subsidies for low-income beneficiaries are paid by CMS on a cost basis.
- Fifth, as noted below, risk corridors result in the government sharing much of the costs of any unexpected variations in costs that occur in the drug benefit.
- For all of these reasons, drug plans are responsible for only a limited share of the total drug cost variations or risk across different kinds of beneficiaries.

Risk Corridors

MMA provided for risk-sharing for Part D benefits. These risk corridors will allow the government to share in any unexpected gains or losses that the plans incur. With the risk corridors, a target amount of plan spending is set to equal the total payments to plans from the government and enrollee premiums, minus the plan's administrative costs assumed in its bid. At the end of the year, costs actually incurred by the plan are then compared to this target amount. The risk corridors are symmetrical in that the government pays PDPs and MA-PDs if costs are above the target and recoups its share of the savings when costs are below the target. In the early years for the program, the risk corridors generally work as follows:

- The plan is fully at risk for the first 2.5 percent of costs above or below a target amount.
- The government pays/keeps 75 percent of the costs/savings that are 2.5 to 5 percent off the target.
- The government pays/keeps 80 percent of the costs/savings that are more than 5 percent off the target.

Further Steps to Limit Risk if Necessary

In addition to the subsidy and risk sharing components of the benefit, the MMA contains two provisions to make sure that the new drug benefit will be available throughout the entire country. In the event that fewer than two drug benefit plan choices provide "full risk" bids to cover beneficiaries in a region, CMS will take further steps to ensure that all 43 million Medicare beneficiaries have access to the drug benefit. First, CMS will consider contracts at a "dialed-down" level of risk, with modified risk corridors. Finally, if the dial-down option is not

successful in obtaining a bidder, CMS will activate a temporary fallback plan under which the government will carry the full risk for actual drug costs until high-quality risk plans are willing to enter the market.

CMS remains confident that these fallback plans will not be needed, given the wide interest that insurers and pharmacy benefit managers have shown in participating in risk-bearing PDPs. But the agency fully intends to have procedures in place to implement fallback plans if necessary so that every area of the country will get access to Medicare drug coverage.

Higher Costs for Beneficiaries Who Enroll Late

Many of the steps described above – such as large subsidies and risk adjustment – enhance the drug plan's ability to provide an effective benefit that is attractive to all types of beneficiaries. The Medicare law encourages beneficiaries who are currently taking few drugs to enroll in the drug benefit. It requires beneficiaries to pay a higher cost for coverage if they do not enroll by mid-May 2006, the end of the first open enrollment period. Beneficiaries may still choose to enter the program later, but, if they do, they will have to pay more. This approach is similar to the higher costs beneficiaries must pay for late enrollment in Medicare Part B, which is one percent of the base beneficiary premium for each uncovered month. This provision does not apply to beneficiaries who have another plan providing credible coverage, such as a retiree plan.

Regional Structure

The drug benefit will be offered regionally. As promised, we established the regions in which PDPs will participate on schedule. Thirty-four regions were designed, based on extensive market studies and feedback from written comments, public meetings, and open door forums. Our structure pays particular attention to getting better coverage and lower costs for those in rural areas and other parts of the country where Medicare has so far provided little or no choice of up-to-date plans. Key principals for establishing these regions include:

- Providing a sufficient number of potential enrollees: Regions must be large enough to support strong networks, but small enough that plans can start right away.
- Consideration of beneficiaries: Our goal was to make PDP regions fit within MA regions as closely as possible so that the regions are transparent to beneficiaries.
- Limiting intra-region cost variation: CMS sought to minimize the variation in average state prescription drug spending within a region.

Flexible Formulary Design:
Providing Access to Up-to-Date Treatments at the Lowest Possible Cost

CMS's goal is to assure that drug plans provide access for all categories of beneficiaries to medically necessary Part D covered drugs while simultaneously limiting the cost of the drug benefit to beneficiaries and taxpayers. In our oversight process, plans are required to submit their formularies to CMS for review. CMS will encourage and approve formularies that rely on the types of drug lists and benefit management approaches that are already in widespread and effective use with senior and disabled populations. CMS will review the plan design to ensure that all the requirements are met using clear checks that will help plans build formularies and structure their bids.

The Indian Health Service will be holding discussions with Prescription Drug Plans related to how Plan formularies compare to the Federal Supply Schedule (FSS) utilized by IHS. It is

difficult, at this point, to determine the degree to which new Prescription Plan formularies will enhance FSS. CMS is committed to providing assistance to Indian Health Care Providers in their efforts to contract with Prescription Drug Plans.

In its review, CMS will rely on existing best practices to ensure that plans provide access to medically necessary drugs and allow plans flexibility in their benefit designs to promote real beneficiary choice. Examples of these best practices include those used in the FEHB Program and other public and private sector programs that serve large numbers of retired and disabled people. To ensure that the benefit is available on January 1, 2006, we will conduct effective reviews of plan offerings within a compressed period of time. CMS expects that these processes and standards will result in formularies that provide appropriate, up-to-date access for beneficiaries without requiring the agency to micromanage the plan development processes. CMS will make sure that plans have the flexibility to meet our goals of giving Medicare beneficiaries access to drugs that are medically necessary to treat their conditions *and* enabling those plans to design and manage their formularies to provide the most affordable benefit possible.

Education and Marketing

CMS will work with a broad array of partners to educate people with Medicare, their care givers, and others who help them about the new Medicare prescription drug benefit and other new Medicare benefits and options. Those partners include SSA and other federal agencies, States, Indian health care providers, employers and unions, and national and community-based organizations. Importantly, CMS will conduct an integrated education campaign with a broad range of public and private partners, and will reach out at the grass roots level to help people with Medicare understand their options to access Medicare prescription drug coverage. Altogether, CMS is investing more than $300 million in this integrated and multi-pronged education effort. These efforts will include simple language fact sheets, detailed publications including the annual "Medicare & You" handbook, direct mail, and community-based grassroots efforts to target specific populations with messages directed to their specific needs (e.g., low income and people with retiree drug coverage).

Over the next few months CMS will be working with the Indian Health Service and Tribal Technical Advisory Group to identify appropriate timeframes and materials that would have the most impact in getting Prescription Drug Benefit information to American Indian and Alaska Native beneficiaries served by the Indian Health Care Provider system.

In the fall of 2005, the “Medicare & You 2006” handbook will be delivered to all Medicare beneficiaries and will outline the specifics of Medicare prescription drug plans and list the Medicare prescription drug plans available in each beneficiary's area. Medicare beneficiaries will be able to get customized local Medicare plan information, including cost, pharmacy, and formulary information, at www.medicare.gov on the web, or by calling 1-800-MEDICARE.